Making It Work! 2004

A Statewide Technical Assistance Conference

For

The Substance Abuse and Crime Prevention Act of 2000 (SACPA)

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Proceedings

First Day

David Deitch welcomed participants to the fourth Making It Work Conference for administration of Proposition 36. He then introduced **Gloria Penner** of the San Diego Public Broadcasting Station KPBS as the emcee for the conference. She described Proposition 36 as a "remarkable opportunity" for many thousands of people to reclaim their lives. "In this climate of financial crisis in the state, it is important to be sure that we are on the right path, and the lives that have been saved, and the money the state has saved as a result of Proposition 36 tell the story." She called attention to the "Managing the Media" publication distributed with the conference materials, pointing out that the story of Proposition 36 successes must be told through the media to reach the people who vote. She then introduced **Kathryn P. Jett,** Director of Alcohol and Drug Programs (ADP) for the State of California.

Jett spoke of the expanding number of people who are familiar with Proposition 36 and what it is doing to help people move out of the criminal justice system into productive lives. She attended a recent drug court graduation ceremony in Sacramento and was moved to see how those completing drug court treatment participated in their recovery, and how they were grateful for the opportunity they were given. "I heard things you do not normally hear…clients thanking the arresting officer for saving their lives…clients saying their Child Protective Services (CPS) worker had made such a difference in their lives…watching family after family that were torn apart now come back together." She also noted the presence of drug court teams who were "tough people" not making Proposition 36 an easy trip for anyone.

Implementation of Proposition 36 is nearly at the halfway point, she said, and she is continually amazed at what is being done in the various counties—"those small successes that are not really small." She is impressed by the fact that all 58 counties were ready to begin implementing the Proposition within the six-month startup time. She recalled the "guiding principles" set forth in the first year: that the state would

establish a first-year baseline for evaluations; that it would promote local control; and, that it would foster collaboration at both the state and local level. "We had to bring people together who ordinarily might not meet to discuss a client's outcome." Counties have recognized that they can solve problems more efficiently if they sit down as a team. In fact, she added, University of California at Los Angeles (UCLA) evaluators have concluded that one of the keys to success for Proposition 36 is having a functional local collaborative. They also identified other practices connected with success, such as allowing "walk-in" assessments, and placing assessment and treatment at the same location.

The midway point also is the time to make adjustments, Jett continued. A new allocation formula can be explored based on what is now known about the Proposition 36 caseload. The Legislature will be considering funding for Proposition 36 in the budget for the 2006-07 fiscal year. "She expects that the next UCLA evaluation report, due in the spring of 2004, will reflect a consistency in the number of offenders coming into the program--about 30,000 a year--and a consistency in the fact that about 55 percent had no prior experience in treatment.

She said the new Director of the Health and Human Services Agency is very interested in Proposition 36 and what has been learned. "We are at a point now with Proposition 36 where people will be listening very intently," she said. "The stories to be told will not be so much at the statewide level where we see a very broad picture. What elected officials are waiting to hear are the stories you will be able to tell about Proposition 36—what works in your county and what does not." She encouraged county representatives to continue sharing their experience and ideas, and to use the media to tell their story to the public. She urged them to contact Lisa Fisher, ADP's Public Information Officer, for information about dealing with the media.

"People from other states are still calling us to find out how we do what we are doing here in the California," Jett said. "They view what we are doing as a way of saving money and getting people into treatment and back to functioning in the community."

Del Sayles-Owen, Deputy Director of the ADP Office of Criminal Justice Collaboration (OCJC), brought participants up to date on developments in SACPA programs since the previous County Lead Agency Implementation Meeting (CLAIM) in October of 2003. Interest is steadily growing in the degree of success that will eventually be described in the report to be released by the UCLA evaluation team. "Given California's extremely weak financial health, we may be wondering what criteria the Legislature will use in casting their votes to continue SACPA funding," she said. Continuing, she pointed out that legislators will be asking such questions as these: Is all the money being spent? Are we able to treat everyone who is eligible for services? Do we have funding gaps? Have we managed the $600 million of funding in a way that will satisfy the public's expectations? "Ultimately, the UCLA evaluation will answer these questions. However, legislators will rely on ADP and other involved entities to provide the data needed to enable a final determination on continuation of the program funding."

As ADP assists counties in implementing Proposition 36, she continued, it is obvious that no two county programs are exactly alike. "There are rarely any one-size-fits-all approaches to problem resolution." She outlined three strategies that UCLA evaluators had found that could be associated with higher "show" rates: placing probation and assessment staff at the same location; allowing "walk-in" assessment; and, using a drug court approach in handling SACPA offenders.

Turning to funding issues, Sayles-Owen said ADP has been asked by the Statewide Advisory Group to examine the allocation formula. A new approach has been formulated in collaboration with ADP's Fiscal Work Group. "The current allocation formula does not take into consideration the SACPA caseload but rather the overall treatment caseload. As a result, counties may not receive allocations proportionate to the number of SACPA clients in treatment..." They may receive greater or lesser amounts, based on their total treatment caseload. Some counties that are now running out of money are making modifications to their programs. Currently, 50 percent is based on the standard allocation methodology, 25 percent on general treatment admissions, and 25 percent on recent drug arrest data. The formula now being considered would distribute the first half of the funding based on the current formula, for the sake of stability and avoiding radical shifts. The balance would be weighted 40 percent on the basis of the SACPA treatment caseload and 10 percent on drug arrests.

There is also a consensus that the issue of unspent funds needs to be dealt with, she continued. Some counties have more funds than they are likely to spend. ADP is considering criteria for evaluating whether a county's unspent funds are excessive. Such criteria would evaluate county expenditures plans and the county's SACPA expenditure history. ADP plans to issue county plan guidelines that include proposed multi-year plans, expenditures, and caseload projections for both Fiscal Years 2004-05 and 2005-06 and for the six-month period from July 1 through December 31 of 2006. Based on the county plans, ADP would determine if a county can reasonably be expected to spend all its funds. "Counties judged by ADP to have deficient SACPA plans would be notified. They would be given an opportunity to take corrective action before any existing allocation is withheld and redistributed because of excessive unspent funds. She emphasized that unspent funds recovered by ADP or returned voluntarily would be redistributed only to those counties that can reasonably be expected to expend the funds. In February, ADP plans to issue two "preliminary allocations." Ordinarily, a plan is based on a single allocation, and the final allocation is made when the Governor's Budget is signed. This time, she said, one allocation will be issued based on the formula in the present regulations and another based on the proposed new formula. ADP is asking counties to base their plans on the new allocation formula.

Sayles-Owen expressed appreciation to Dr. William Ford of Health Systems Research, Inc., for his assistance in the study of the impacts of various allocation formula scenarios. The Center for Substance Abuse Treatment made Dr. Ford available to ADP for this work.

Turning to audit issues, she said the Department's audit staff was offering counties some advice on preparing for an audit, with emphasis on these points:

1) maintain critical documentation, including time studies and other records to document expenses being charged to the SACPA trust fund;
2) allocate shared costs proportionally among different funding sources, and finally,
3) be well-prepared for the audit.

On another front, Sayles-Owen reported that the Parolee Subcommittee has been working on data reconciliation, involving data from the California Department of Corrections (CDC), the Board of Prison Terms (BPT), the California Alcohol and Drug Data System (CADDS) and the counties' data systems. ADP is also responding to legislative requests for information regarding parole revocations and the tracking of clients through the parole process—using a flow chart similar to the one used for probationers. Regarding mental health and dual diagnosis issues, she said Los Angeles County has agreed to pilot a Parolee Mental Health Screening program using CDC mental health services for Proposition 36 parolees. Meanwhile, ADP continues to examine the interface between the Substance Abuse Services Coordinating Agencies (SASCA), and Proposition 36. "We hope to release guidance to counties in this area very soon," she said.

Sayles-Owen then provided an explanation of the decision by the 6th Appellate District in the *People vs. Guzman* case, which expands SACPA eligibility. "It requires that persons on probation for non-disqualifying offenses (other than violent and serious felonies) who commit eligible offenses (such as non-violent drug possession) must be sentenced to treatment like other SACPA-eligible offenders. "This would create three, rather than two, broad categories of persons who become eligible for SACPA."

On November 12, 2003, the California Supreme Court announced that it had agreed to review the Guzman decision, which means the 6th Appellate District decision is no longer applicable. A decision from the Supreme Court is expected later this year. She pointed out that Senate Bill 84 in the current Legislature, if enacted, would bring existing California statutes into alignment with the Guzman decision.

Meanwhile, Senate Bill 762 was signed into law and became effective January 1, 2004. This new law was sponsored by law enforcement addresses "date rape" drugs and makes clear that Proposition 36 aims at the treatment of those with substance abuse problems. It states: "The term 'nonviolent possession offense' means the unlawful personal use, possession for personal use, or transportation for personal use of any controlled substance." ADP will be issuing an All County Lead Agency (ACLA) letter on this subject shortly, Sayles-Owen said. She also called attention to other lead-agency letters issued since the last CLAIM conference. ACLA 03-09 clarifies that under-utilized capacity is allowable under certain circumstances. ACLA 03-10 deals with the SACPA Reporting Information System (SRIS). "With the assistance of California State University at Bakersfield we were able to implement a project in this area, resulting in

our providing counties with a completely revised and more user-friendly SRIS User Manual.

In other areas, the County Alcohol and Drug Program Administrators Association of California (CADPAAC) has asked for clarification of the source of funds that can be used for repayments when an audit finds that the SACPA trust fund has been used inappropriately. Also a letter clarifying CADDS reporting instructions, answering questions that have arisen regarding treatment admissions, will be issued.

In conclusion, Sayles-Owen outlined the "formidable challenges" facing the last half of SACPA authorization:

- Modifying the SACPA allocation to make it more fair and equitable.
- Placing funds where funds are most needed.
- Maintaining SACPA accountability.
- Ensuring accurate data reporting.

"As you participate in meetings, workshops and breakouts over the next three days, I ask that each of you continually visualize your role in the SACPA implementation process, not as an island but as an integrated component of a statewide project team."

Basic Concepts of Addiction Science

Carlton K. Erickson, PhD, Director of the Addiction Science Research and Education Center, in the College of Pharmacy at the University of Texas, Austin, discussed the basic concepts of addiction science. As a pharmacologist accustomed to seeing patients with depression and other mental conditions improve after taking medication, he said he was impressed by the fact that people at 12-step meetings and at the Betty Ford Center were getting better without medication—"sitting around talking, sharing, crying, hugging, laughing." He said the success of such "talk therapy" leads many people to think that alcoholism and addiction are behavioral problems, but research is showing that it is a chronic medical disease that deserves all the attention and treatment given to the so-called "good" diseases such as diabetes, hypertension and others.

People with addiction disease have been "S.P.A.M.D.!" with stigma, prejudice, anger, misunderstanding and discrimination, Erickson said. "They have been given poor or no insurance coverage, punishment instead of treatment...and no respect! But, he said "increased public understanding of the causes of addiction is going to reduce such discrimination." New research can destroy myths about drug abuse and addiction. Among those myths: club drugs and date rape drugs will not harm you; the new smokable heroin, called black tar heroin, is non-addicting; everyone who uses cocaine or heroin is addicted (actually, only 17 percent of those who use cocaine become addicted); alcoholics can stop drinking, by merely going to a few AA meetings; and punishment is effective in reducing addiction. To find accurate information about these

and other addiction subjects, he recommended the Web-site of the University of Texas Addiction Science Research and Education Center: www.utexas.edu/research/asrec

Erickson pointed out that the list of "addictions" present in society has expanded from alcohol and drugs to include gambling, sex, the internet, work, food, cell phones, television, sugar, etc., even shoes. This is a misuse of the word "addiction." He said the Diagnostic and Statistical Manual (DSM) of mental disorders and the International Criteria for Disease (ICD) point out the difference between chemical or substance *abuse* and chemical or substance *dependence.* It is critical, especially for those working with Proposition 36, to understand the difference between abuse and dependence. Abuse can be caused by rebellion, money, boredom, thrill-seeking, experimentation, desperation, or self-medication. "Drug abuse is a problem for the United States to solve, but it is not a disease," he said. Dependence is caused by genetics and brain chemistry sensitivity, with input from the environment. "This is the disease of chemical dependency which we loosely call addiction."

There is also a difference in ways to approach the abuse problem and the disease of dependence, he continued. Abuse responds to education, coercion, punishment, environmental change, maturation, pressure to stop, and life events. He gave the example of students who may abuse alcohol and drink heavily enough to look like alcoholics when they are in college. A great majority later become social drinkers. Only about five percent of campus drinkers develop alcohol dependence. Dependence, on the other hand, requires some form of "treatment" to positively affect abnormal brain function to reduce the need for a drug. "The reason the person needs the drug is that the person's brain is connected with the drug in such a special way that the drug is perceived to them to have the same need they have for food, water and air. When people dependent on a drug say they can not stop, it is not that they do not want to stop; it is that they can not stop." The essential feature of dependency is impaired control—loss of control within an episode of alcohol or drug use, and inability to abstain between episodes.

Erickson said he thinks it waters down the term "addiction" to apply it to activities like gambling, sex, and so forth. "In actuality these 'process addictions' are more like obsessive compulsive disorders than drug problems. The DSM and ICD dependence criteria apply only to chemicals. For example, the DSM refers to "obsessive gambling behavior," not to an addiction or dependence involving gambling. "I would suggest we get away from this loose idea of addictions and try to narrow it down, make it more scientific and more medical, so people will understand what we are talking about." When addiction is discussed with others, it can be described as a "brain disease"--better known as chemical dependency.

A survey in the 1990s interviewing families on their mental health problems produced data on drug use indicating that only 15 to 16 percent of those who used cocaine became dependent on the drug, a figure which is close to the 17 to 18 percent cited by the National Institute on Drug Abuse. The same survey showed that 12 to 13 percent of alcohol users become dependent. For marijuana, the figure is eight percent. Other

findings shed light on how dependence occurs. Among those dependent on cocaine, five to six percent became dependent in the first year of use, while 80 percent became dependent within three years. Other research reported by the Institute of Medicine has determined that 32 percent of people who try smoking become dependent on nicotine, and 23 percent of heroin users become dependent. Information is more scant on so-called club drugs, but indications are that the dependence potential for methamphetamine is high, for Rohypnol it is moderate, and for ketamine and LSD it is low. No data is available on the dependence potential of the drug called Ecstasy. "It is becoming fairly well understood that drugs do not all have an equal likelihood of producing dependence in a given group of individuals," Erickson said. This leads to the question of why drugs have a different impact on different individuals. "Some people have what it takes to get the disease and some people do not have what it takes."

Erickson went on to describe how drugs work in the body, based on recent biological research. Dependence or impaired control occurs in an area of the brain known as the Medial Forebrain Bundle, also referred to as Mesolimbic Dopamine System, or sometimes called the "pleasure pathway." With the use of slides, he outlined the functions of various parts of the brain that appear to be involved in chemical dependency, which results when something goes wrong with the way nerve cells communicate. Pleasurable experiences release dopamine to go down the "pleasure pathway." If something is wrong with neurotransmitters in the system, the use of a drug may cause a dopamine release that leads drug dependent people to say that use of the drug makes them "feel normal." The drug takes on a special meaning to these people and may lead to their dependence on it. The "drug of choice" appears to depend on what neurotransmitter system is involved.

The research indicates that these malfunctions may be genetic or may have their origin in drug use, brain trauma, child abuse, stress, or low socio-economic conditions. It appears that environmental factors are not the primary cause but may help create the disease in someone who is genetically predisposed. Family, twin and adoption studies are showing that over 60 percent of people with alcohol dependence have a hereditary predisposition for the disease. Children and grandchildren of alcoholics have a risk of becoming an alcoholic that is three to four times the risk for the general population. Familial alcoholism runs in families, but non-familial alcoholism "seems to burst out of nowhere." The best way of summarizing these findings is not to say that alcohol dependence is a "genetic disease" but that "the tendency to become alcohol dependent is inherited." An individual's vulnerability or risk is changed if there are alcoholics in the family.

As a brain chemistry disease, he continued, cases range from mild to severe. Treatment seems to "click" quickly with some people and they never use drugs again. Other people may receive "all the treatment in the world" and never get better because their form of the disease is so severe as to be untreatable. "Methadone and nicotine maintenance is evidence that some people require a chemical to overcome the non-normal transmitter system." He said methadone programs can be successful if they are run properly.

Erickson said an important point is that dependence is not a loss of "will power." The main problem is a subconscious pathway in the brain over which a person has no control, and the frontal cortex where decisions are made is not working properly. "Thus, dependence is not primarily under conscious control." This leads to a distinction between society's attitude toward drug abusers and drug dependent persons. "Drug abusers make decisions to use drugs, and when they hurt others, they deserve appropriate punishment. Drug dependent individuals have responsibility for their actions under the influence of drugs, and they have responsibility for their own treatment. This means getting into treatment and staying there. We do not make it easy for them to do this—California is an exception—because in most states there are waiting lists for getting into treatment." He urged participants to remember that alcohol and drugs do not cause alcoholism and drug dependence—the problem is in the brain.

He went on to review the various options for treatment of dependence, ranging from 12-step programs to new medications. "Harm reduction," though often rejected because it does not call for total abstinence, can be a valuable step in reducing the consequences of alcohol and drug abuse, such as drunk driving and spread of disease through dirty needles. Some "anti-craving" medications are coming into use. These drugs should not be used alone but should be accompanied by counseling or talk therapy. Research shows that grief, anger and learning can change brain chemistry. And watching the effect of therapy at the Betty Ford Center, he concluded that talking to others in an emotional group setting can also change brain chemistry. "This does not fix the neurotransmitter dis-regulation, but what we do in behavioral talk therapies is push the brain chemistry more back toward normal so the individual has a greater chance to live—as the recovering community says—happy, joyous and free." He displayed images of brain scans that show differences between pre-treatment and post-treatment scans of the same brain. At this point, it is not clear whether this change results from the absence of drug use or is the effect of treatment, or a combination of both.

In conclusion, Erickson emphasized that new research is changing our understanding of dependence, or addiction, and learning this new information requires a willingness to give up old ideas and learn new ones. He asked participants to join him in a pledge: "I promise that what I've heard here today, whatever I choose to believe, I will tell as many other people as I can." The nation must understand, he stressed, that addiction or dependence is a brain disease that is just as devastating, just as understandable, and just as treatable as the so-called good diseases such as diabetes, hypertension and cancer.

In a brief question period, Erickson was asked why the science he had just reviewed is not being taught in medical and other professional schools. "Just as with other medical diseases, it took a while for new information to be inculcated into our medical and other professional curricula," Erickson replied. "It will happen, but it is very, very slow. The stigma, prejudice, anger and misunderstanding is still prevalent in medical schools as it is elsewhere in the nation. They do not want to talk about it."

Joe O'Flaherty of Placer County asked why methamphetamine is relegated to the category of a club drug when, in rural counties like Placer, it is practically the only problem. Erickson said methamphetamine is a horrible problem in many communities and an effort is being made to develop new treatment for methamphetamine dependence. A vaccine is under development. There are places in the country where methamphetamine is not used at all. It seems to be found in "hot pockets" around the country.

When asked about the issue of drug legalization, Erickson said this is an obvious "hot button," and he would be a middle-of-the-roader on the issue. "I can understand both sides of the issue. I tend to lean more toward the side of keeping drugs illegal. When I say that, I need to break down the drugs. You can not think of legalizing heroin as much as you can think about legalizing marijuana. Those are two separate issues as far as I am concerned. Even with marijuana we have to be careful. We do not have all the research in, even though as a pharmacologist I can see that marijuana is quite safe compared to nicotine and alcohol. As far as we know it has no lethal dose in humans or long term effects. But long-term research is still incomplete…I have told my kids they may see their friends using marijuana and they have to make their own choice, but bear in mind that marijuana may be the worst drug in the world when the final research is in."

Effective Use of Rewards and Sanctions

Douglas B. Marlowe, J.D., Ph.D., of the Treatment Research Institute at the University of Pennsylvania, explained that there were four things one can do to modify a person's behavior. "I can give you a sanction, I can give you a reward, I can take a sanction away, or I can take a reward away." He gave examples of how each action—punishment, positive reinforcement, negative reinforcement or a response cost--could be applied, explaining that these four actions are the basics of behavioral modification techniques. He pointed out that punishment and response cost would be used to get someone to stop doing something bad, while negative or positive reinforcement would be used to get him to start doing something good. Rewarding appropriate behavior feels better and has fewer negative side effects than punishing inappropriate behavior.

The most important thing about behavior modification is the *certainty* of sanctions and rewards, he continued. Modification techniques can be looked on in terms of the ratios of sanctions to infractions or the ratio of rewards to achievements. An "FR-1" is when a reward or sanction is provided for each act, an FR-2 for every two acts, etc. Giving a reward for every clean urine sample is an FR-1 ratio; for every fifth clean sample is an FR-5. "If one of your clients gives you a dirty urine specimen you are not naïve enough to think you caught that client's one instance of drug use. You probably caught one out of 10 or one out of 30. So, frequently, you have a client on an FR-10 or FR-30 schedule." It is a law of human behavior, he added, that the closer one gets to an FR-1 schedule in sanctions and rewards the better the effects on behavior. The further one gets away from FR-1, the effect gets exponentially weaker. "FR-10 is not twice as bad as FR-5, it is 25 times as bad." It is extremely important to detect target behaviors when

using behavioral modification techniques, Marlowe said. Thus, it is important to do urinalyses on a random schedule because, any time a use of drugs is not detected, the effect of a sanction is weakened. Giving a client a "second chance" after a violation also weakens the effect of sanctions, but there are circumstances when a second chance can be appropriate. A client who returns to drug use, and then voluntarily reports it to his probation officer or a sponsor, withholding the possible sanction becomes a negative reinforcement of the desired drug-free behavior.

The next most important quality is *celerity,* the swiftness or immediacy of applying sanctions or rewards. There is also a geometric reduction in the effect when there is a lack of celerity in applying sanctions and rewards. A sanction applied on Friday for a drug use that occurred on Monday has lost the power of celerity. If the client followed the rules Tuesday through Thursday, receiving the sanction on Friday could actually have a negative effect. Marlowe said his research team studied the effect of status hearings on drug court clients. Research showed that high-risk drug offenders who had not done well in earlier diversions had an 80 percent graduation rate and provided an average of 11 out of 14 clean urine specimens when they had court status hearings every two weeks. When they were not having regular status hearings, they were graduating only 20 percent of the time and having only 2 out of 14 clean urine specimens. "So we saw threefold or fourfold increase in positive outcomes when the behavior or conduct of clients was reviewed on a bi-weekly basis, with sanctions or rewards applied closer in time to their behavior."

The next most important quality is *fairness.* Marlowe listed several issues affecting fairness, and pointed out that lack of fairness could lead to retaliatory behavior. A sanction should not be out of proportion to the behavior. People in similar circumstances should be treated the same. There should be procedural justice which gives clients confidence that they were being treated fairly in court procedures. Clients should be told clearly and specifically in advance what is expected of them. Finally, sanctions should be based on what the clients do, not who they are, thus punishing the act not the individual.

The fourth most important factor is *magnitude.* "We all go to magnitude first…but it is less important than certainty, celerity and fairness," Marlowe said. The difficulty of acting with certainty, celerity and fairness makes it tempting to resort to sanctions of magnitude, but this is ineffectual and violates the fairness principle. With the same principle of the frog placed in water that is slowly brought to a boil, sanctions or rewards that start out mild and get stronger lead to "habituation," diminishing their effectiveness. By the same token, "ceiling effects" which start too strong in a sanction limit the choice of tougher sanctions if necessary in the future. "Once you have used your biggest bomb, your client knows you have used your biggest bomb, too, and you are pretty much out of ammunition. It is a good idea to save your stronger sanctions and bigger rewards for later." He went on to describe "shaping." For example, a client who does not show up for his first counseling session would get a high-magnitude sanction. The same client delivering a dirty urine specimen might receive a lower magnitude sanction. The principle is: high magnitude for short-term proximal behaviors, low magnitude for

distal behaviors more removed in time. Also, simply raising the possibility of receiving high-magnitude rewards can be reinforcing when seeking a desired behavior.

Marlowe then turned to people who tend to be defiant and give up when the going gets rough. Unfairness can trigger this behavior, as can uncertainty about what behavior is expected. Researchers identified "learned helplessness" as an aspect of programs that is likely to make clients give up when the going gets tough. A client who is punished and does not know why, or who is punished for something that is out of his control, lapses into learned helplessness. The way to combat this is through predictability and controllability in the way the client perceives sanctions and rewards.

Programs have target behaviors—things they want their clients to do as they move through treatment, Marlowe continued. "The question is, do you shoot at all these behaviors at once or do you order them or line them up? You want to focus first on proximal behaviors with higher magnitude sanctions or rewards, and lower magnitude sanctions and rewards for distal behaviors." One way to meet this problem is to have "phases" in the program as clients progress, with different expectations in different phases. He also pointed out that it may be easy for a client to do something that triggers an immediate sanction, but it is difficult to carry out the long-term commitment that leads to graduation from the program. "It is very important to catch your clients doing well," he said, pointing out that one judge makes sure to provide verbal praise to clients just for showing up, although that kind of positive reinforcement is more valuable early in the program rather than later.

He went on to explain why it is important to have at least as much or more positive reinforcement in a program than punishment. There are negative side-effects to punishment, among them: escape or avoidance behaviors, over-generalization (associating a sanction with a judge or probation officer who applies it), and superstition (myths that associate sanctions with unrelated events, such as the mood of a judge on Tuesdays). Also punishment does not teach a client what to do since it concentrates on bad behavior rather than the good behavior that is rewarded. Finally, a program relying exclusively on sanctions leaves clients to fall back to their baseline when they graduate and suddenly have no more prospect of punishment for a no-longer-sanctioned behavior.

There are also pitfalls associated with use of the "carrot" as an inducement to desired behavior. The problems include a public perception of "coddling" that seems to be rewarding people for doing what most people do without rewards. There is a tendency toward complacency when rewards are provided for relatively low achievement or performance, and with complacency the performance will not get any better. A sense of entitlement can result when rewards are expected and are no longer given, and a reward system can lower intrinsic motivation when simply doing the right thing earns rewards.

In summary, Marlowe reiterated that certainty and celerity are the most important principles for using sanctions and rewards for behavioral modification. Use higher

magnitude sanctions and rewards for proximal behaviors; lower magnitude for distal behaviors. Ensure sanctions and rewards are predictable and based on attainable goals. Focus as much on rewarding desired behaviors as on punishing undesired behaviors. Beware of individualism that leads to perceptions that different people are being treated differently. He urged participants to build structure into the planning of their programs to avoid "shoot from the hip" decisions. He also pointed out that good assessments of individuals are an important priority before using sanctions and rewards, and the team should keep accurate track of where individuals are as they move through the program.

Second Day

Kathryn P. Jett, opening the second day of the conference, said that the previous day's county planning workshops identified a number of issues that needed to be clarified. Confusion has arisen over the data to be used in the new allocation formula. She urged county team members to read county planning instructions carefully because they address many questions raised in the past. ADP can provide technical assistance to clarify these issues. The Department also has been working on a package of new regulations to govern the certification of alcohol and drug counselors. The draft new regulations are in the public review process and can be viewed on-line. She also announced that a drug court training session will be offered in Sacramento County on April 26, 2004.

"The Department has been trying to keep the program steady," addressing criticisms of the program as we celebrate successes. When we went into Proposition 36, treatment did not change much but the whole criminal justice system had to change, and at the pinnacle were the courts. The courts and the judges have been our strongest allies in implementation, and we owe them a debt of gratitude for changing their system of court proceedings…Now we are going to be non-adversarial, a different practice in the courtroom, and they have been wonderful in adapting to this." She urged that county teams reach out to police chiefs and sheriffs, as well as district attorneys, to assure that they understand what constitutes success in Proposition 36 efforts; for example, comparing results in treating addicts with treating a disease like diabetes. They also need to know how the programs are dealing with offenders who are not in compliance, so they know there are consequences for people who do not show up for treatment. "If you are not talking with them, they will not know that."

Dual Diagnosis

Marc Schuckit, M.D., Director of the Alcohol and Drug Treatment Program, University of California, San Diego, and Director of the Alcohol Research Center at the Veteran's Affairs (VA) San Diego Healthcare System, said it was a challenge to discuss dual diagnosis, or co-morbidity, before such a diverse group of people seeing Proposition 36 from different perspectives. The material he would present would explain what should

be going through a clinician's mind if one were trying to advise Proposition 36 team members about what to do when confronted with clients who appear to suffer from both drug or alcohol dependence and a mental disorder. His presentation would include some new material he has received from focus groups since he delivered a similar lecture at an earlier CLAIM conference.

"From time immemorial people have sought out substances…substances to focus their attention, to help them feel more relaxed, or for no other reason than wouldn't it be fun to feel different," he said. "We need to recognize that illicit substances are a part of our lives and that, in fact, it is impossible to be in a health care or any public-related job without running into substance use." People who are regularly into substance use can get confused and non-functional, he continued. However, considering that 60 percent of high school seniors have used an illicit substance, it is apparent that most of them do not go on to develop severe, pervasive problems related to substance use or substance dependence. The lifetime risk for developing alcohol dependence in the United States is about 15 percent for men and about half of that for women. Another ten percent will become dependent primarily on illicit substances, such as marijuana, amphetamines and cocaine.

On top of this, there is a lifetime risk of about ten percent for developing a severe anxiety syndrome, while the risk for developing a severe depressive episode, the risk is about 15 percent in women and 10 percent in men. "If we are in a public health or public-related job we'd better learn how to deal with these kinds of issues," he said. "If substances of abuse make pre-existing psychiatric disorders worse, and if people who are worse find their way into our system, it should be no surprise that it would be moderately common to see psychiatric disorders and substance use problems together." Care-givers need to know how to determine whether symptoms of a psychiatric disorder in a person who is dependent on a substance are temporary and will go away, or whether they indicate a psychiatric disorder that needs to be addressed independently of the substance use problem.

A clinician must first establish a diagnosis before deciding how to treat a new patient with obvious symptoms of mental illness. The person might be schizophrenic or be in severe depression, or might have a brain tumor. Or the person's condition might be induced by heavy use of alcohol or drugs. Even in the latter case, the person is still psychotic. "But if the condition is related only to amphetamines or cocaine, the good news is that about 100 percent of them will get un-psychotic once they get off the drugs of abuse." He emphasized that to make a diagnosis it is necessary to consider not one symptom but a whole group of symptoms, and it may be that there is a diagnosis of multiple disorders that have to be treated independently over a period of time.

He cited a recent study finding that there is a two-out-of-three chance that a person entering treatment for alcohol or drug dependence also has symptoms of mental illness. About 40 or 50 percent of the people entering treatment under Proposition 36 meet the criteria for a major depressive disorder, a serious anxiety disorder, or some other mental disorder. What needs to be determined is whether these symptoms are likely to

have been caused by the substance use and, therefore, likely to disappear fairly quickly, or whether they are likely to require long-term independent treatment. “If a depression, anxiety or other psychiatric syndrome begins as part of intoxication or part of withdrawal—and that’s the only time you see it—it is very likely to go away with abstinence, usually within one month of abstinence.” Determining the significance of such symptoms requires a series of observations over time.

Schuckit then discussed the categories of drugs people take to get high. The categories are based on the effects each drug produces. For example, with a person who is hearing voices and believes he is the victim of a plot, the only drugs capable of producing those symptoms are inhalants. The two major offenders causing the most serious problems—either a substance-abused condition or a long-term psychiatric disorder—are depressants and stimulants. Depressants, such as sleeping pills and the Valium-type tranquilizers, may mimic a lot of psychiatric symptoms during intoxication and withdrawal. When first taken, they produce a high similar to that from alcohol, and withdrawal also mimics the letdown after intoxication from alcohol. Symptoms during withdrawal may include insomnia, nervousness, fear of social situations, and palpitations and shortness of breath. These symptoms can look like major depressive or anxiety disorders. Withdrawal from heavy use of stimulants—such as methamphetamine or cocaine—can lead to symptoms of severe depression for several days and, with very heavy use, the withdrawal symptoms may look like schizophrenia. About half of the time these symptoms are seen, they reflect only the withdrawal from drugs. The other half of the time they may reflect an actual psychiatric disorder requiring separate treatment.

Schuckit explained how he explores a patient’s history to help determine the significance of symptoms. He begins by learning at what age the patient first began using his drug; then, he asks when the patient became dependent on it; and, when the patient began experiencing problems in his life. He finds out if the patient had symptoms of depression or anxiety during times when he was not using drugs. If symptoms of mental problems existed before becoming dependent on drugs, it is likely that those problems developed independently of drug use. If they are associated only with periods of heavy drug use, the drug may be causing the symptoms, in which case the symptoms disappear within a month after abstinence begins. “Most alcohol and drug dependent people regularly have periods of abstinence,” he said, pointing out that the absence of psychiatric symptoms during those periods indicates their association with the drug. During the first four weeks after withdrawal, cognitive behavioral therapy can be used to help a patient examine his own feelings--to understand the nature of his depression or anxiety.

He described the case of a 38-year-old woman with alcohol dependence who said she had “always” been depressed. In creating a timeline of her history, however, it was found that she was about 23 years of age at the onset of her alcohol dependence, a time which coincided with the beginning of her problem with depression. Further, she said she had not been depressed during a year she was pregnant and avoided drinking. Finally, it was determined that she had severe depressive episodes only when she was

drinking heavily. After a few weeks of "talk therapy," her depression symptoms had disappeared without any anti-depressant medications. Some studies indicate that about 50 percent of alcoholics exhibit symptoms of depression but only 15 percent turn out to have depression that is independent of their drinking problem.

Schuckit described how the issue of co-morbidity is handled at the San Diego VA hospital. Rather than start a separate program for treating dual diagnosis, the hospital maintains an inpatient alcohol and drug treatment program and a separate inpatient mental health treatment program. Persons in both units are trained in issues of co-morbidity or dual diagnosis, learning how a substance-dependent person may present symptoms of a psychiatric disorder. When psychiatric symptoms clear up, as they usually do within a week or so, a patient is transferred from the mental health unit to the alcohol and drug treatment program. When patients are found to have a mental condition not associated with substance use, they are stabilized with treatment for that condition and then transferred to the alcohol and drug unit. "We had these two units already operating and only had to teach them how to talk to each other," he said, indicating it would have been expensive to maintain a separate co-morbidity inpatient program.

He listed three principles that he and his staff adhere to: "The first is that we serve the patients, and when there are patients who are difficult to diagnose or have two independent disorders, we have to be flexible or that patient will fall between the cracks." Second, members of the staff try to avoid turf wars. "When it appears people from the two sides are starting to get irritated with each other, we call a meeting and try to get around the problems that are occurring. Third, "we use whatever has been shown to work," and treatment is individualized to the extent possible. He added that the hospital does not hesitate to take advantage of services available in the community, and he urged Proposition 36 teams to consider referring dual diagnosis clients who are veterans to the VA hospital.

Schuckit noted that California has seen an epidemic of methamphetamine use and "more than our share" of cocaine use. During intoxication, these drugs mimic anxiety disorders, while during withdrawal they mimic depression. Persons who are heavily into these drugs, however, may also show symptoms of psychosis, including schizophrenia. In these cases, it may be appropriate to use anti-psychotic medications for a short time, even though the symptoms may have developed in connection with stimulant use. He uses the timeline approach outlined earlier to determine if the symptoms were present before the person became heavily involved with the drug.

He described the case of a 23-year-old woman who exhibited psychotic symptoms as a high school student several years before beginning use of amphetamines, and it became evident that drug use made her case worse. After stopping the use of amphetamines, she needed further treatment for her psychotic condition which was independent of drug use. He added that persons with schizophrenia and manic depressive disease appear to have an increased risk of developing substance dependence.

"I want to remind you that, if someone comes in with psychiatric syndromes, I establish a diagnosis; and, if it is a substance use disorder and a psychiatric disorder, I establish a timeline and choose my treatment based on the diagnosis."

In a question period, it was asked whether attention deficit disorder or hyperactivity often turned up in the history of persons with substance use disorders. Schuckit said that "ornery" kids who frequently get into trouble have a high risk for problems with substance use. But, those with the classic definition of attention deficit disorder without a conduct problem do not have an elevated risk. Another questioner asked if a person whose substance use grew out of a mood disorder were treated for the mood disorder would the substance abuse problem go away. Typically that's not the case, Schuckit said, and while in individual cases it may occur, it is unlikely. In answer to another question he said that dual diagnosis patients are harder to treat than those who have one disorder or another alone, and that he believes abstinence should be the goal of treatment even when it is unlikely that certain patients will achieve it.

Motivating the Drug-Involved Offender

Judge **Stephen Manley** of Santa Clara County introduced **C. West Huddleston**, **III**, Director of the National Drug Court Institute, with the observation that the drug court model has proved to be the most efficient and successful way to convince clients to enter treatment and motivate them to stay in the treatment program as mandated by Proposition 36. He said it was "terrible," this far into implementation of Proposition 36, that "there are still counties in this state in which the court has no relationship with treatment." In those counties where a drug court system that is working well, there is a strong collaboration and evidence of success in implementing Proposition 36. "What many of you in the treatment field may not understand is that the greatest advocates for treatment throughout the United States are drug courts and those who work in them."

Huddleston reviewed the findings of three surveys that reflect the current degree of drug use in American society—the National Survey on Drug Use and Health (formerly the "Household survey"), the Monitoring the Future Survey, and the Drug Abuse Warning Network. These surveys show that 30 percent of 12th graders, 26 percent of 10th graders, and 14.1 percent of 8th graders report binge drinking in the past month. Some 22 million Americans (9.4 percent of the population 12 and older) are dependent on alcohol and drugs. Some 3.5 million people (1.5 percent of the population 12 and over) received some kind of alcohol or drug treatment in 2002. He said the amount of binge drinking by young people—that is, drinking 12 ounces of alcohol at a sitting at least three times a week—is one of the "most scary" statistics ever to come out of these surveys.

He pointed out the "vast difference" between the number of Americans who are dependent on alcohol or drugs, and the number of those who are receiving treatment, and said there is obviously "something wrong." The surveys show that illicit drug use

has been going up again for three years in a row after three decades of decline. About 19.5 million Americans, or 8.3 percent of the population age 12 and older, are illicit drug users. About 14 million of them use marijuana; of those 14 million, 8 million use marijuana 20 days or more a month. "You can see we are creeping up to the nation's all-time high of 25 million illicit drug users last seen in 1979." He urged participants to focus on another statistic: 4 million addicts, who represent two percent of the U.S. population, use two-thirds of the drugs. These heavy drug users are treatment-wise, have been through treatment and had multiple failures, and are getting sicker, he said.

He went on to indicate that 18-25 year olds are using drugs at a higher rate than the rest of the population. From the audience, he elicited the fact that California is concerned about an increase in smoking and snorting heroin. He pointed out there were more deaths from drug overdoses than from homicides in Orlando, Florida, last year. The heavy use of methamphetamine familiar in California is now being seen in Midwestern states. Meanwhile the use of Ecstasy nationwide has tripled since 1999. Meanwhile, 11 million Americans reported driving under the influence of an illicit drug at some time in 2002, up from 8 million in 2001. The 17,419 Americans killed in traffic crashes involving impaired drivers is the equivalent of a 737 airliner crashing every day of the year.

Turning to the criminal justice system, Huddleston noted that over half of all jail inmates were under supervision at the time of their most recent arrest: one-third on probation, one-eighth on parole, and one-eighth on bail or bond. Two-thirds of adult arrestees and more than one-half of juvenile arrestees test positive for at least one illicit drug. "From 1979 to the present, the number of drug and alcohol users in the United States declined by 45 percent, but the percentage of crime related to substance use has spiraled upward," he said. "The social scientists say we are a nation of fewer addicts and fewer users but those addicts and users are more harmful and destructive than ever before."

This leads to the philosophical question of whether society should deal with drug users through punishment or rehabilitation, he continued. Some answers can be found in criminal justice statistics. The Bureau of Justice Statistics has reported that 29.9 percent of prisoners released in 1998 in 15 states were rearrested within six months, and 67 percent were rearrested within three years. These were prisoners released from state prisons where they received no treatment for a drug or alcohol problem. A study by the Research Institute at the University of Pennsylvania found that 68 percent of drug abusers re-offend after their release, with 47 percent convicted of a new crime and 25 percent reincarcerated for a new crime. The study showed that 75 percent of probationers or parolees were reincarcerated within their three-year probationary or parole period, including 25 percent for new crimes and 50 percent for violations such as drug use or absconding.

Huddleston noted that Judge Dennis Challeen of the National Judicial College, a judge in Minnesota who retired in 1985, once declared that there were two kinds of offenders: those we are afraid of, who should be locked up, and those we are mad at, who hurt

themselves with substance abuse. For the latter, he found the following inconsistency in dealing with them with imprisonment:

> We want them to have self-worth, so we destroy their self-worth. We want them to be responsible, so we take away all responsibility. We want them to be positive and constructive, so we degrade them and make them useless. We want them to be trustworthy, so we put them where there is no trust. We want them to be non-violent, so we put them where violence is all around them. We want them to be kind and loving people, so we subject them to hatred and cruelty. We want them to quit being the tough guy, so we put them where the tough guy is respected. We want them to quit hanging around losers, so we put all the losers in the state under one roof. We want them to quit exploiting us, so we put them where they exploit each other. We want them to take control of their lives and quit being a parasite on society, so we make them totally dependent on us.

Then, Huddleston looked at the alternative: not sending any of them to prison but sending them all to treatment. In that event, at least 50 percent fail to show up for intake, 40 to 80 percent drop out of outpatient treatment in three months, and 90 percent drop out or are kicked out in 12 months. In other words, a year later--without any supervision or pressure on them to stay in treatment--there are only two left out of the original 100. Typically, of those staying in treatment, only half are clean and sober after one year. Being sent to treatment is only a beginning, he said. “There is a lot more [that] has to happen after they get there.”

Raising the question of why drug users can not change, he found an answer in his own personal experience, when promises of one sort or another are not kept. Also, Carlo di Clementi provided this answer: “Remaining addicted becomes easier than trying to change.” This is the case in spite of all the personal problems and losses that addiction entails. He pointed to the case of the actor John Belushi, who kept using drugs to the point of death in spite of his success as an actor and the admiration and wealth it brought him.

Huddleston turned to the fundamental question of how to keep people in treatment, which he described as a “complex illness” with biological, psychological and sociological implications. Research shows there is “an entire constellation of barriers” getting in the way of getting addicts to make changes in their lives, including environmental factors, personality traits, co-occurring disorders, genetics, social conditioning, and psychological conditioning. “These barriers are all working against you, the clinician.” “Focusing on the genetic influence,” he said, “it is known that genetic programming affects both obesity and smoking in persons who continue harmful habits despite the threats to their health. The genetic influence is also believed to be involved in 50 percent of cases of alcoholism and 17 percent of cases of drug addiction.”

He said brain research at the University of Wisconsin has found that there are 13 “pleasure centers” in the brain that are stimulated by such normal activities as sex,

eating chocolate, music, laughter, etc. Brain scans are showing that two stimulant drugs--cocaine and crystal methamphetamine--stimulate all 13 of the pleasure centers at once and “hijack” the brain. Use of such drugs begins to change the brain because it cannot handle such stimulation; eventually the pleasure centers can only be stimulated by the drug. It takes two to five years for the brain to return to normal functioning after use of the drugs is stopped. During that period a person may feel depression, anxiety, and boredom, which can lead to relapse. Addicts are beset with many “defense tactics” that keep them committed to their addiction. Treatment can help overcome this resistance—but not if the client is not there!

He then cited studies that spanned 30 years and covered 70,000 patients in federally-funded substance abuse treatment, showing that the length of time spent in treatment is a reliable predictor of post-treatment outcomes. “The longer they stay in treatment, the better they do.” Furthermore, a treatment episode of less than 90 days is totally ineffective, and the most effective results come from treatment spanning one year or more. Another major contributor to success is “sobriety maintenance” after the conclusion of treatment. The study also shows that coerced clients tended to stay in treatment longer than those entering voluntarily. “Coercion is a nasty word in our vocabularies but it does not need to be, because it serves a purpose,” Huddleston said. It can keep a client in treatment long enough for recovery to take place and can reduce the number dropping out. “That is the promise of blending treatment with our criminal justice system.” The National Institute on Alcohol Abuse and Alcoholism (NIAAA) found that employees pressured into treatment by their employers are more likely to recover from alcoholism. The Institute of Medicine findings indicate that, contrary to clinicians’ fears about coercion, pressure from the criminal justice system does not threaten the effectiveness of treatment.

A judge, Huddleston continued, is the greatest “change agent” in the life of an addict. The judge has the power to expedite the process of getting addicts into treatment before losing them to their addictions, and keeping the addict engaged in treatment long enough to receive treatment benefits. “This calls for a system of collaboration--putting egos aside, inviting treatment and probation to the table, and, coupled with prosecutor and public defender and case manager and police, working together to get this individual clean and sober and on their way.” Clinicians often correlate addiction with three other diseases—hypertension, diabetes, and asthma—because all four can be controlled by doing what one is supposed to do. Huddleston used the example of his daughter, who suffers from asthma and whose condition depends on whether she uses an inhaler as prescribed. He speculated on what condition she would be in if her doctor had “kicked her out of treatment” for not using the inhaler before she accepted the necessity of doing so to enjoy good health.

Drug courts represent a “common sense” approach to the addiction problem; with everyone working together to get people into treatment and keeping them there long enough for the benefits to take hold. Huddleston said the 1,500 drug courts in the United States have a 71 percent retention rate, outperforming all other strategies being brought to bear on the problem. Drug court graduates have a 5.4 percent re-arrest rate

compared to a 21.5 percent rate for a control group. A survey looking at 2,000 graduates of the 100 largest drug courts last year found that after one year only 16.4 percent has been rearrested and only 27.5 percent after two years. The State of Oregon calculated that for every $1 spent on drug courts the state saves $10 in tax funds.

"We can capitalize on the trauma and consequences of arrest to get people into treatment and to keep them there longer," he said. "The accountability that occurs in the community for defendants and the system is unparalleled." A recent study of outpatient treatment providers by Maryland University showed that 20 percent of the time the counselor doesn't show up for group meetings with patients. This is not likely to happen, he pointed out, when judges and prosecutors and public defenders and probation officers are working together with treatment providers.

Post-Traumatic Stress Disorder (PTSD)

Susan Crimmins, PhD, MSW an Associate Professor at the California State University at Los Angeles, Department of Criminal Justice and Criminalistics, described herself as a researcher as well as a clinician. Recently she directed an institute on trauma and violence funded by grants from the National Institute on Drug Abuse. She said her presentation would deal primarily with PSTD and how it affects offender populations, as well as some findings from her experience in dealing with offenders in her clinical practice.

PTSD is defined as an "anxiety disorder that develops in response to a traumatic event," as "memory gone awry," and as "incomplete physiological responses suspended in fear." The definition best known to clinicians is from the American Psychology Association: "A complex psychological condition that interferes with social functioning." The DSM –IV criteria reveals that it is found in persons who have experienced, witnessed, and/or confronted an event or events involving actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others. A powerful component is the feeling of helplessness. Referring this to offender populations, she said there are many situations in which they feel particularly helpless.

The "re-experiencing symptoms" set forth by DSM-IV (one or more to be present) are that one has recurrent and intrusive distressing recollections of the event, recurrent and trouble dreams about the event, is acting or feeling as if the trauma were recurring, has intense psychological distress at exposure to cues that symbolize the trauma, and has a physiological reaction when exposed to those clues.

The avoidance systems (three or more) are:

- avoiding thoughts, feelings or conversations associated with the trauma;
- avoiding activities, places or people that arouse recollections of the trauma;
- an inability to recall an important aspect of the trauma;
- markedly diminished interest or participation in significant activities;

- feelings of detachment or estrangement from others;
- a restricted range of affect; and/or
- a sense of a foreshortened future.

The arousal symptoms (two or more) are:

- difficulty falling or staying asleep;
- irritability or outbursts of anger;
- difficulty concentrating;
- hyper-vigilance; and,
- an exaggerated startle response.

Criteria addressing the duration of the disturbance include any of the foregoing symptoms that persist for more than one month, and clinically significant distress or impairment in social, occupational or other important areas of functioning.

Studies shows the PTSD exists in 15 to 24 percent of the general population, she continued, but in incarcerated populations the range is from 65 to 82 percent. This means inmates are three times more likely to have PTSD after exposure to a trauma as compared to the general population. "It is definitely prevalent and is something we may not be aware of." Studies also show substance abusers are more likely to have PTSD than the general population, and that female substance abusers are more likely to have PTSD than males. (Few studies of PTSD in males have been conducted in the United States, apparently because of an assumption that males do not experience PTSD, she pointed out. Sometimes it is under the surface, and a clinician needs experience to evaluate it.)

Crimmins also discussed the brain activity associated with PTSD—a response to trauma that could be described as "fight, flight, or freeze." The fright or freeze piece has been shown to be the most distressing and damaging, and occurs in most victims. It is believed the males have more of a fight or flight reaction, while females are more likely to have a fright or freeze reaction. "Sometimes we do not recognize PTSD because we are not aware of all these possibilities that could occur." The brain is unable to process the traumatic experience and integrate it with other experiences and it remains suppressed. The person may be unable to describe the event, and may always be on "hyper-alert," watchful and checking people out. This may have implications for people with PTSD who are confined in institutions where they have concerns about their safety in general.

She described how the responses of fight, flight and freeze are seen in different behaviors. Her experience as a clinician working in a prison indicated that violence in prison populations can be reduced by working with prisoners with PTSD and reducing their aggression. "As budget cuts are happening more and more and prisons are going to get more crowded, with fewer options for what to do with offenders, we are going to see an increase in violence and we need to know how to respond to that." The "flight" response may lead to use of substances to get away from the intensity of the emotions. The "freeze" response is like a deer in the headlights, with a sense of numbness and

immobility, even amnesia about the actual event that occurred. PTSD thus leads to a wide variety of symptoms that include mood swings, panic attacks, hyperactivity, flashbacks, etc. The symptoms may lead to diminished emotional responses, inability to make commitments, chronic fatigue or very low energy, depression, and psychosomatic illness that often is interpreted as an effort to escape from a program and get on sick call.

Crimmins turned to methods of treatment of PTSD, saying that the treatment needs to be geared to how the person is processing information.

The processes range from:

- *cognitive*, which involves thoughts and perceptions;
- *affective*, which involves feelings and emotions;
- *somatic*, exhibited in posture and body memories;
- *behavioral*, with passive or active states; and,
- *spiritua*l, dealing with soul, essence and energetic fields.

She described how each of these channels of processing would be exhibited in individual behavior, and how cognitive behavioral therapy begins with the person's thoughts and seeks to change them in a way that relieves the trauma and confronts feared situations. Psycho-pharmacological treatment includes Prozac and other medications that suppress symptoms but do not create real change. When power and control are taken away from PTSD victims, as is often the case for offenders, it is one of the worst things that can happen to them, she said. "It is not helping them heal, and their fears are just reinforced." She described other forms of therapy, such as the newer alternatives of thought field therapy (TFT) and eye movement desensitization and reprocessing (EMDR), including ways to help people deal with fears that are out of proportion to a threat. Physical activities such as foot-tapping or "bilateral stimulation" can help calm them. She also discussed "energy medicine" that includes such techniques as massage and homeopathy. She led the participants in examples of thumping, tapping, and rocking on the feet that can help produce a calming effect.

Crimmins reviewed the problems that arise when PTSD people are in confinement. What might seem to be a routine day for others would not be a routine day for someone with PTSD—someone whose fears, sense of confinement, and reactions to external stimuli are more pronounced. "People with PTSD need more space," she said. Certain signals can make them feel they are in danger again. A goal is to bring the "locus of control" back to the person. Again, physical exercises, such as "rocking" to find a sense of balance and a center, can help.

Finally, Crimmins listed points to remember in efforts to facilitate healing, including:

- do no harm;
- safety and self-care;
- speak in modulated tones;

- eliminate or minimize potential triggers, such as sights and sounds associated with the trauma;
- steps that regulate or "self-soothe;"
- foster and maintain appropriate boundaries;
- build trust and balance;
- develop body awareness;
- always reduce pressure (encourage options/choices); and,
- encourage resource building (physical, psychological, social and spiritual).

Third Day

The Friday session opened with a panel reporting on the meetings of participants from like-size counties on the first two days of the conference. David Deitch introduced the panel as follows:

> **Al Rodriguez**, Manager of Alcohol, Drug and Mental Health Services in Santa Barbara County, reporting for the group including: Kern, Monterey, Placer, San Luis Obispo, Santa Barbara, Tulare, and Ventura Counties.
>
> **Philip J. Smith**, Director of Modoc County Health Services, reporting for the group including: Alpine, Amador, Calaveras, Inyo, Mariposa, Modoc, Mono, Plumas, San Benito, Sierra, and Tuolumne Counties.
>
> **Frank Lewis**, Program Manager for Riverside County Mental Health and Substance Abuse, reporting for the group including: Fresno, Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties.
>
> **Joseph J. Solga**, Public Defender Attorney from Napa County, reporting for the group including: Butte, Colusa, El Dorado, Glenn, Lake, Mendocino, Napa, Nevada, Sutter, Yolo, and Yuba Counties.
>
> **Jim Sanders**, Supervising Probation Officer for Sacramento County, reporting for the group including: Alameda, Contra Costa, Sacramento, San Francisco, and Santa Clara Counties.
>
> **Rick McKay**, Drug and Alcohol Director for the Tehama County Health Services Agency, reporting for the group including: Del Norte, Humboldt, Imperial, Kings, Lassen, Madera, Merced, Shasta, Siskiyou and Tehama Counties.
>
> **Allan Hardcastle**, Judge of the Superior Court of Sonoma County, reporting for the group including: Marin, San Joaquin, San Mateo, Santa Cruz, Solano, Sonoma, and Stanislaus Counties.

Deitch asked the panelists to report on how their groups might have answered the questions posed to stimulate discussion at their sessions.

The first multi-part question:

a. *Has your county made modifications to your program because of funding concerns?*
b. *What kind of changes have been implemented?*
c. *What has been the impact of those changes?*
d. *What strategies were considered but rejected?*
e. *How do you ensure positive treatment outcomes?*

Smith stated that his group, representing small counties, discussed not only the lack of funds but also the utilization of funds. While some counties have enough Proposition 36 clients to spend all their funds, other counties have too few clients and money left over because they are not permitted to utilize funds for other purposes. Also, several counties are unable to provide the complete range of services to Proposition 36 clients. In Tehama County, for example, there are no sober living facilities. "Once people leave rehab, they go directly back into the community. It would be nice to give them the structure…to protect them a little bit more when they go back to their jobs." One roadblock is that a facility opened with Proposition 36 funds could be used only by Proposition 36 clients.

Rodriguez pointed out some counties used funds from non-Proposition 36 programs to provide Proposition 36 services, leading to a curtailment of treatment programs not related to Proposition 36. He added that the use of a "pupilometer" to indicate drug use had helped reduce costs by avoiding the need for a full urinalysis in every case. In response to a question, he replied that in some small counties Proposition 36 cases are a "natural fit" with existing drug courts.

Lewis reported that the large counties in his group also were redirecting resources, stating, "I am impressed by the energy people are devoting to thinking of innovative ways to keep Proposition 36 clients together in the flow of treatment." As funding decreases, a tendency to change a six-month treatment program to a 90-day program or make similar adjustments exists. All five counties in his group have made changes to meet the funding problem.

Solga addressed concerns his group had regarding the growing caseloads for case managers and probation officers. Case managers have been taking over services that originally treatment providers handled. One county started to charge clients more for their treatment, to the point that some might not be able to pay. Another county was considering establishing a cut-off date for new Proposition 36 clients because they were not sure whether funds would be available for additional clients.

Sanders stated that Sacramento County saved enough funds from the first and second year to provide for additional services in the future, such as developing a sober living environment as a Proposition 36 service. The impact of statewide cuts in probation department staffing would be felt in the future. He also noted that San Francisco County appeared to be doing well in all aspects of its program, and that this might

reflect the unique situation of having a combined city and county government with funds available from two sources.

McKay said that in Tehama County probation was continued beyond completion of treatment in order to make the clients pay their fees. "There is a concern that if we do not keep that leverage, we will have trouble getting our fees." Other counties are also concerned about the impact at the county level of proposed statewide cuts in probation funding. Financial problems have forced his county to abandon some services originally planned, such as employing case managers, and providing more liberally for residential treatment. Matching clients with the level of service indicated in their evaluation has not always been possible. "We end up triaging clients and end up getting only the most severe into residential treatment." Most counties in the group do not provide for sober living facilities as an alternative to residential treatment, he added. Another county wanted to hire a licensed clinician for its program but, instead, hired two drug and alcohol counselors to get more value for the cost. One county offers clients an opportunity to continue treatment at their own expense if they are threatened with losing Proposition 36 status for one reason or another.

Hardcastle reported that counties in his group had many of the same concerns. In Sonoma County treatment will continue beyond 90 days only if the treatment provider can provide clinical justification for the longer period. Counties, such as Santa Cruz County are reducing the span of residential treatment. Specifically, treatment was reduced from six to two months, with an attempt to get clients into a sober living environment for a longer period. Another county spent two-thirds of its drug treatment money in one-half of the allotted time, posing the possibility that the county would have to rely on an "honor system" for reporting drug use. The issue of "under-treatment" was raised as a concern.

Santa Barbara, according to Rodriguez, had expanded its detox services by locating Proposition 36 detox beds within an existing homeless program, thus saving the extra costs of providing a free-standing detox program.

The next question posed was: *Should program funding not be reauthorized in the 2006/07 fiscal year, what kinds of strategies are being explored or recommended for exploration?*

Rodriguez said that, while his group did not discuss this question extensively, the point was made that fee-based programs can be self-supporting, such as those for DUI and domestic violence offenders. This might solve some Proposition 36 funding issues. "If we are making a presumption that other kinds of clients can pay such costs, then we should give it some thought," he asserted. Another thought on the funding problem: "We are going to have to be more aggressive as a collaborative. We have the courts, probation, district attorneys, public defenders, as well as treatment people—in many ways a very powerful force across the state if we are all willing to agree to be on-message with this problem with the State Legislature. We ought to organize ourselves behind the message that this is a program that cannot be de-funded."

Smith reported that the smaller counties with drug courts feel it will be difficult to continue with Proposition 36 services at the current level and the program may have to change to the drug court model. He added that what Rodriguez said about DUI programs being self-sustaining is not necessarily true. Smith stated that he will be going to his board this month to tell them that he is dismantling the county DUI program. "We have been supporting it with regular program funds and we can not continue to do that." The population in some counties is not large enough to sustain DUI, anger management, and domestic violence programs."

Deitch raised the question of whether unexpended funds might be rolled over for use in a future year. Smith replied this was an issue that needed to be taken to the Legislature. These funds could be used for services to clients who need them but do not technically meet the requirement for Proposition 36. As the law now stands, this cannot be done.

Reporting for his group of large counties, Lewis commented that boards of supervisors and state legislators need to be convinced that that Proposition 36 is a cost-saving measure and the program should continue to be funded. Otherwise, the group saw few alternatives. Solga observed the small counties felt the same way, faced with the loss of all the good work they had put in to create their Proposition 36 programs. Similarly, Hardcastle asserted that if someone would come before him and say he had been convicted of a non-violent drug possession offense and wanted treatment, as a judge he would have to order it, and how that treatment is provided would not really be his concern. Handling these cases with the resources for existing drug courts would not be realistic, he added.

Rodriguez noted one issue to be resolved is whether the program is considered an "entitlement," in which case other state and federal dollars might have to be diverted to continue it, leading to a withdrawal of services to non-Proposition 36 clients of alcohol and drug programs.

Sanders affirmed he would hate to see all the collaboration developed during the Proposition 36 implementation crumble away if funding were cut off in the future. It might still be possible to make it work, but it would be difficult. By observing that there was a feeling in his county since Proposition 36 was providing money for probation services, the county should withhold the equivalent in other moneys that go to support probation. "It is going to be an ongoing battle to make it all work," he concluded.

McKay stated his group thinks it is unrealistic to worry about funding in 2006/07 fiscal year when counties are "scrambling" to make it through the current period. The group feels it is important that counties get the word out about their successes with Proposition 36, and several voiced a hope that more statewide data would be forthcoming from ADP. The sheriff in his county is asking whether Proposition 36 is "really working," and a meeting is scheduled soon to provide county leaders with

information about local successes, and also about the accountability built into the system to assure that offenders do not “get by” too easily.

Lewis pointed out that UCLA evaluators are working hard to come up with outcome information that would show legislators that Proposition 36 is working. He echoed the earlier appeal for the State to provide counties with such data as soon as possible. Smith interjected the question of whether legal issues would be raised if the counties were not able to provide the required “best practice” treatment for Proposition 36 offenders due to lack of funding.

Panelists then reported on discussions around the third question: *What practices have been implemented that are helpful in dealing with dual diagnosis clients?*

Rodriguez observed that it appeared all counties have developed a good assessment structure. In a discussion of Marc Schuckit’s presentation earlier in the day, some indicated that their experience led them to doubt that only 20 percent of the people with dual diagnosis symptoms at the beginning of treatment would turn out to have actual psychiatric disorders. On one hand, some counties have treatment programs that do not accept clients who are taking psychotropic medications; on the other hand, some counties have mental health systems that are reluctant to work with clients with co-occurring disorders. Other counties have been successful in keeping dual diagnosis patients in either mental health or addiction treatment without making referrals from one system to the other. Monterey and Placer counties have been using integrated assessment teams to identify dual diagnosis clients and steer them toward appropriate treatment. One county employs a Clinical Psychologist to help identify the needs of such clients. In Santa Barbara County, some mental health clinicians offer to work with dual diagnosis Proposition 36 clients, because of the support they receive from their addiction treatment programs.

Smith mentioned his small county group discussed problems with the integration of services. Many small counties, do not have a psychiatrist in residence in the county. In his county, for instance, there are only four days of psychiatric services per month when a physician comes down from Oregon. Some counties use a Registered Nurse from the mental health side to do medication management for the dual-diagnosed population, and some have assigned mental health workers to do alcohol and drug screening. In Modoc County, alcohol and drug counselors have been teamed with mental health workers to go on emergency calls when a 5150 assessment needs to be done. Some counties have a lengthy waiting list to receive mental health treatment, while smaller counties may be only treating the “big three”—psychosis, severe depression and bipolar disorder. Some counties have a Licensed Clinician on their Proposition 36 team, and in some there has been discussion of expanding board and care contracts for the mentally ill to include drug and alcohol and dually diagnosed clients.

Lewis reported that his large county group had quite a bit of dialogue on the dual diagnosis issue. The feeling is that the drafters of Proposition 36 did not consider how expensive it would be to treat dual diagnosis clients. “As I see it, my colleagues have

done some outstanding jobs in trying to come up with some innovative ways of handling their dual diagnosis population." San Diego has contracted with UCSD for psychiatric service in doing assessments. Riverside has a mobile team that can transport clients from the court to a facility for psychiatric assessment and then to a treatment facility. Orange County has a grant covering medication and services for this population. Los Angeles has an assessment center located near a treatment facility. San Bernardino County has expanded its dual diagnosis residential beds and made use of its mental health courts for the program. "Needless to say, we need a lot more dollars to be effective in dealing with this population."

Solga observed Butte County appears to be in a class by itself, providing treatment for the 50 percent of its Proposition 36 clients who have a dual diagnosis. The rest of the counties in his group have virtually no services for dual diagnosis. In Napa County, the drug treatment providers will not take clients who are mentally ill, and the mental health providers will not take clients who are addicted to drugs. He hopes that Napa can get help from neighboring counties to deal with this problem.

Sanders agreed that not enough consideration was given to the dual diagnosis problem when Proposition 36 was drafted. In his group, Contra Costa County and San Francisco County had a better way of treating such clients compared to what was being done in his County of Sacramento. One idea advanced is that increasing the time between progress reports for dual diagnosis clients might offer an opportunity for a better reading of their status. Another participant described how Contra Costa County developed its own in-house mental health program to handle Proposition 36 dual diagnosis clients, using "a small percentage of our budget to serve a large percentage of our clients." Sanders added that an effort is being made in Sacramento to enlist law enforcement help in "red flagging" offenders who might be candidates for early assessment for dual diagnosis.

McKay reported that some in his small county group do assessments upon entry into a treatment program and then do referrals to mental systems for dual diagnosis clients, but with different degrees of success in making those referrals. In other counties, treatment for dual diagnosis is incorporated into alcohol and drug treatment with a strong referral system. Tehama County is moving toward a "no wrong door" policy offering dual services wherever clients enter the system. If 40 to 60 percent of Proposition 36 offenders are, in fact, dual diagnosis clients, as was reported at an earlier session, then his county appears to be missing many of them because they are not being identified at nearly that level. Another issue that came up involved certification of programs serving dual diagnosis clients. There is some concern that people are receiving Proposition 36 treatment and services from mental health programs that may not be certified for Proposition 36 dollars. There also were comments from some counties that alcohol and drug treatment programs appeared to be doing better treating dual diagnosis cases than their local mental health systems.

Hardcastle remarked the discussion of this question in his group was an eye-opener for him. Many of the dual diagnosis clients do not have mental health problems severe

enough to justify seeking help from mental health providers. This affects their ability to obtain medications and creates other problems in placing them in appropriate treatment programs. Counties having success with such clients are those with an aggressive case management system, and "good clinicians making good assessments from the get-go."

Smith added that in Modoc County, when clients are still in an acute intoxication phase, there is no place to take them while waiting to do an adequate assessment. "We have worked out a 'padded cell' arrangement at the county jail, and provide an attendant who watches in case the person takes an action that may be dangerous. Our hospital will not take them in this condition."

Reports then moved on to the next question set:

a. *What strategies are you using in your counties to engage and retain clients in treatment?*
b. *What innovative practices are you using in your counties related to the Proposition 36 program?*

Rodriguez reported the annual evaluation in Santa Barbara County led to identification of some very clear predictors to identify those clients who are going to drop out of the program. For example, those with no employment and lower levels of education have higher dropout rates. Those with more recent and frequent drug use experience have higher dropout rates. Clients with opiate use have higher dropout rates than those using other drugs. The challenge is to develop ways to keep such clients in the program rather than making a presumption that they are likely to fall out. "We are looking at engagement activities to keep such clients in."

Another problem is clients with learning disabilities, and some counties are developing learning disability screens as part of their assessment process or are using the local adult education system which provides such screening to students enrolled in the community college system. One county works with a state university campus to get the benefit of about 100 hours a week of student intern time. One county uses "Saturday morning sanctioning" for clients who are having trouble keeping their treatment obligations during the week. Kern County is using a "passport" or point system so that some clients can self-navigate through the treatment process rather than having a structure imposed upon them. Kern County has developed a way to deal with the developmentally disabled among its Proposition 36 clients. David Deitch pointed out that enrolling clients in a community college may open the way to obtaining services that could not be provided within Proposition 36 budgets.

Smith remarked Modoc County integrated its Proposition 36 program with the drug court program that has a judge who is very "parental" and maintains a very positive interaction with the group. The county is also moving toward a three-year involvement in "extended recovery assistance" for clients even though they have completed their Proposition 36 treatment.

Lewis observed the larger counties could offer four specific suggestions for retaining clients and improving the success rate. First, clients should get into treatment as quickly as possible after a judge's decision that they meet Proposition 36 criteria. Second, there is a need for aggressive case management which looks at such issues as whether there are marital problems going on, whether education referrals would be helpful, etc., and to get clients linked with resources providing assistance. Third, there must be collaboration with all parties concerned with the case, with intensive case reviews seeking input from all, which reduces a manipulation of the system by the client. Fourth is monitoring. "We have to get that client back to the court in two weeks or thirty days, or whatever, which tells the client that this is something serious."

Sanders believes that practicing active supervision in the field is one of the best ways to keep clients in the program. San Francisco uses a warrant team to bring clients back into treatment. Those who "slip away" need to be told that they are going to be held accountable. A probation officer in Contra Costa County says that at times he will pick up a client and personally deliver him to a new place of treatment. "In probation supervision, coercion does work."

McKay had read a research article mentioning that candy bars were a good incentive for treatment, so Tehama County is now including candy bars in its order of supplies from Office Depot. "We put them in a big bowl on the front desk. I can not tell you how this is affecting retention but it sure is popular." The county is doing other things to make the office a more welcoming place, and to overcome a "disconnect" between residential and outpatient treatment, with some patients disappearing after they leave residential treatment. Case management, which would help deal with this problem, is unfortunately an area in which counties are cutting back.

Hardcastle commented two counties in his small county group provided an interesting contrast. In one county Proposition 36 was working very well, and in the other it was not working well. For the county where the effort was working well, everyone involved was at the table. For the county where it was not working well, the district attorney was missing from the table. In the latter county, violations were used primarily to expel people from the program. In his own county, he said, violations were taken as a reason to ramp up the treatment. "I think that illustrates what really needs to happen to keep people engaged in treatment. If you're going to have a collaborative court, it only works when everyone is collaborating and has an eye on the same target."

Deitch ended the session concluding that the reports from the various county groups reflected the concerns, innovations, contributions and thought about problem-solving of the entire group. "My conclusion is that it is a lucky person indeed who gets into Proposition 36."

In the final plenary session of the Making It Work conference, **Kathryn P. Jett** thanked the participants for allowing ADP to observe what the counties are doing at this "fifty-yard marker" in the implementation and continuing administration of Proposition 36. Continuing, Jett confirmed that it is coming through loud and clear that the small rural

counties are experiencing many challenges in meeting the requirements of SACPA, and the State will make every effort to accommodate some of the issues that are coming up in rural areas. She also offered assurance that the proposed changes in the allocation formula would shift as few dollars as possible and would not amount to a radical stripping of funds from one county to another.

“Things are working well with Proposition 36. The integrity and ability to tackle problems head-on make this program different from any other I’ve seen in county government.”

The session ended with an inspirational message from Kent Amos, Founder and CEO of the Community Academy Charter School in Washington, DC.

Breakout Sessions

Breakout sessions during the three-day conference included workshops on various aspects of Proposition 36 programs, including treatment and administrative issues, as well as sessions for like-size counties to exchange information on their problems and solutions in implementing SACPA. Scribes assigned to the breakout sessions provided notes and summaries for inclusion in these proceedings. Following are the highlights of the sessions as provided by the scribes.

Judges Technical Assistance

***Judge Stephen Manley** of the Santa Clara County Superior Court led a panel of judges discussing court issues of interest to SACPA stakeholders. Members of the panel were Commissioner Nancy Cisneros of the Fresno County Superior Court, Judge Rogelio Flores of the Santa Barbara Superior Court, Judge Gary E. Ransom of the Sacramento County Superior Court, and Judge Doris L. Shockley of the Yolo County Superior Court.*

The judges addressed how the SACPA team--the court, district attorney, defense attorney, and probation office--determines offender eligibility for SACPA and encourages offenders to accept treatment. The approaches vary among the counties. When the team works together and reaches agreement, counties are able to find and utilize innovative approaches to help offenders in treatment.

Judge Manley asked what judges do or say in court to encourage offenders to accept treatment and stay in treatment. The judges agreed that many choices and many factors come into play, and the role of the SACPA team is important. Close interaction with parole and probation systems facilitates the process. Judge Ransom makes sure offenders understand their sentences, should they fail in treatment. Judge Flores does not like to include information on what happened; he prefers, instead, to give the offender credit for trying treatment. One judge reported that a SACPA parolee told him that when a parolee is released from prison is a good time to offer treatment if the offender is SACPA-eligible at that time.

The judges concurred that SACPA courts manage a broad spectrum of drug offender treatment and diversion cases. They often find they manage cases with multiple charges in addition to Proposition 36 violations.

Judge Manley asked how judges make a determination of successful completion of treatment. Judges responded that typically the determination is based on a team recommendation. Judge Ransom has a team that meets and recommends whether clients have successfully completed treatment. Judge Cisneros reported that probation, the public defender, treatment, and the judge meet to assess a client's status. Judge Manley noted that it is important to make a distinction between completion of treatment and completion of the SACPA program requirements.

The judges are seeing probation increasingly taking a solution oriented role. This is being done without compromising their duty to protect public safety. Judge Manley asked whether the panel ever remanded on a first (non-drug) violation. Judges answered that typically this does not happen. However, the team gets involved and the action taken will vary from county to county.

In conclusion, Judge Manley surmised the judges' comments as reflecting the importance of collaboration among local teams. Teams are also demonstrating flexibility and use their varied perspectives to adopt strategies that meet offenders' individual cases.

New Parole Model and Other Initiatives

Facilitators: Stephen K. Goya, Regional Administrator, and Joel Ossmann, Parole Agent III, of the Parole and Community Services Division of the California Department of Corrections.

Joe Ossmann discussed the findings of the Little Hoover Commission, which called for various improvements in the parole system in California. The Commission recommended that wardens develop a pre-release program, that more sanctions be developed for infractions by parolees, and that the cases of parolees committing serious new offenses be given more scrutiny. In response to these recommendations the Department of Corrections has developed several new programs:

- A Drug Treatment Furlough Program will include releasing inmates 120 days early into community residential treatment, emphasizing a need for finding employment and creating more structure in their lives.

- The Folsom Transitional Treatment Facility being activated in 2004 will provide two substance abuse programs affording inmates and parolees who have substance abuse problems an opportunity to address the issues surrounding their addiction.

- A new Substance Abuse Treatment Control Unit (SATCU) calls for 30 days of in-custody drug treatment, followed by 90 days of aftercare which will be provided primarily on an outpatient basis.

Joe Ossmann, Steve Goya and Brenda Johnson answered many questions regarding the new parole model. More than 50 persons attended the workshop.

Substance Abuse Treatment Using the Transtheoretical Model and Motivational Interviewing

Facilitator: Mary Marden Velasquez, Department of Family Practice and Community Medicine, University of Texas-Houston Medical Center.

The main point of Velasquez' presentation was to offer answers to the question: "How can we facilitate change?" She led the participants through an exercise demonstrating how behavior might or might not be changed on the basis of a hypothetical study showing that watching television causes brain damage.

In discussing motivational interviewing to achieve behavioral change, she stressed the importance of taking a gentle approach toward clients, even when they are showing discouraging results. Criticism can make clients become defensive and shut down and make relapse more likely. She explained the use of the "confidence ruler, the importance ruler, and the balance scale" as explained in a motivational interviewing booklet distributed to participants.

Other points to remember in interviewing: practice your body-language skills, avoid imposing a hypothesis on your client, be curious but not investigative, never place a label on anyone, and always ask open-ended questions. Interviewers should let clients tell their story and how they got where they are. Through this technique they may even hear themselves for the first time and understand the implications of the behaviors they have chosen.

Adapting AOD Treatment for Persons with Cognitive Limitations

Facilitator: John de Miranda, EdM, Executive Director, National Association on Alcohol, Drugs and Disability

De Miranda explained that cognitive limitations could result from brain injury or be the result of developmental disabilities such as mental retardation, autism, cerebral palsy and epilepsy and other seizure disorders. The characteristics include low IQ and low education and learning disorders.

He went on to cover issues that can arise when providing treatment for alcoholism and addiction to persons with cognitive limitations. Accessibility to a treatment site may depend, for instance, on whether there are "curb cuts" that eliminate the barrier of curbings at street corners. Any printed materials given to clients should be explained carefully.

Intake interviews should include questions regarding personal physical limitations, including issues such as back problems that would affect attendance at group meetings. Appropriate questions also could be asked to determine reading ability and the last grade completed in school. Some clients may have hidden disabilities, as revealed in a

New York study identifying 32 percent of clients with secondary problems not related to alcohol or drug use or their cognitive limitations.

Participants were urged to get further information from the California Alcohol, Drug and Disability Technical Assistance Project.

Relapse Prevention

Facilitator: Li-Hsiang (Lisa) Hong, M.A., Senior Learning Skills Counselor, Center for Criminality and Addiction Research Training & Application (CARTA), University of California, San Diego.

The focus of the Relapse Prevention workshop was to briefly review scientific brain discoveries that confirm the biologic etiology of post drug-use craving, i.e., "triggers" that frequently lead to relapse; and to explore a set of cognitive behavioral affective approaches that can help individuals both prepare for and respond to such craving impulses. Slides used in the presentation can be viewed by contacting Alexis Marguglio at amarguglio@ucsd.edu.

Serving the Dually Diagnosed Proposition 36 Client: A Collaborative Approach

Facilitator: Marc F. Bono, Psy.D., Alcohol and Other Drug Services, Contra Costa County.

Dr. Bono outlined ways to determine if a client is dually diagnosed, beginning with the simple expedient of asking. The client may have been informed in the past of his or her dual diagnosis. Otherwise the preliminary assessment should seek to identify areas of possible concern and a need for further assessment, leading to a diagnosis.

A dual diagnosis is common among persons with substance use disorders, so it is important to follow the procedure outlined in Dr. Marc Schuckit is presentation aimed at determining whether symptoms of a mental disorder are a result of drug use or exist independently of drug use. In the former case, the client would be referred eventually to alcohol or drug treatment without a classification of dual diagnosis.

Because dual diagnosis clients have a variety of needs, the most successful outcomes of treatment result from a multi-disciplinary approach involving a parole agent, case manager, psychiatrist and a primary counselor. Each case requires not only an accurate assessment and diagnosis but also intensive monitoring.

Orange County Jail: Best Choice In Custody Treatment

Facilitators: Susan Bellonzi, Correctional Programs Manager, Orange County Sheriff's Department; Laura Mason, MSW, Program Administrator, CHE Correctional Services LLC; Luis Orta, CDAC, Program Coordinator, CHE Correctional Services LLC.

The facilitators provided the following information about the Orange County program called BEST for "behavior, education, socialization and transition:"

> The Inmate Education Team program includes three to 40 hours of instruction per week and provides inmates with certificates of participation and completion. About 5,800 inmates are currently eligible to participate in the program, which is voluntary and depends upon acceptance of an application. Approximately 43 percent of applicants are accepted. Prisoners who have committed violent crimes, for example, are not eligible. Prior to their incarceration, about 40 percent of participating inmates were daily users of methamphetamine, 26 percent were daily users of alcohol, 29 percent were daily users of marijuana, and 14 percent were injecting illegal substances. They have been arrested an average of 15 times in their lifetimes.

The program focuses on four areas:

- *Academic Improvement:* General education development, lessons in government, English as a second language, and the Working for Inmate Literacy Now, a literacy tutoring program.

- *Vocational Education*: Inmates are offered training in horticulture, cabinetry, construction, welding, commercial painting, skid steer, computer business skills, food service and commercial sewing.

- *Job Development:* Preparation to enter the work force includes a job development trades workshop and programs of the Workforce Investment Act (WIA) and the Welfare to Work (WTW) programs.

- *Life Skills Development:* This area includes substance abuse recovery, parenting, health and life skills.

Education programs are carried out in partnership with the Rancho Santiago College District, the Orange County Department of Education, the Community Services Agency, the Orange County Public Library, and READ Literacy Services.

The program helps inmates overcome high levels of anxiety and stress, and develop a trusting relationship with therapists, counselors, the courts, probation officers, health care providers and judges. Currently, the recidivism rate among participants is only ten percent.

Managing the Media

Facilitator: Dotty Diemer, Senior Vice-President, Rogers and Associates.

The workshop was developed around the *Media Manual: A How-to Guide for Proposition 36 Communications*, prepared by Rogers and Associates and distributed to all conference participants.

Diemer's presentation included a review of managing the media, how to get the message out, how to talk about a product or service, understanding the media, key message development, and conducting media interviews. Among the main elements of success in working with the media are:

- carefully crafting key messages;
- creating a unified voice;
- knowing the audience and targeting it;
- being honest;
- preparing for every interview; and,
- knowing reporters and their publications or other outlets.

The workshop included a mock exercise in which a volunteer received a call from a reporter.

Using the media on behalf of Proposition 36 includes showcasing successful treatment facilities, highlighting graduations, and releasing trend data which shows the effectiveness of Proposition 36 as public policy.

Breakouts by Like-Sized Counties

Participants from various counties were invited to attend one of seven breakout sessions based on their comparable size. Each group was asked to explore the same set of questions:

1. *Has your county made modifications to its Proposition 36 program because of funding concerns?*

2. *What kinds of strategies are being explored in case funding is not reauthorized in the 2006-07 fiscal year?*

3. *How do your treatment plans for dealing with dual diagnosis clients? (Explain and discuss.)*

4. *What strategies are you using in your counties to engage and retain Proposition 36 clients in treatment?*

5. *What innovative practices are you using in your counties related to Proposition 36?*

A spokesperson for each group provided a summary of the breakout sessions at a plenary session on the third day of the conference. In addition, a volunteer took notes which are summarized below.

Representatives of Alpine, Amador, Calaveras, Inyo, Mariposa, Modoc, Mono, Plumas, San Benito, Sierra and Tuolumne

Modifications due to funding concerns: There is value in combining Proposition 36 with drug court in counties where a drug court is available. Money is saved by using a pupilometer to detect drug use rather than a more expensive urinalysis. Some counties have problems because Proposition 36 funds cannot be used for treating clients not eligible for SACPA. Keeping people on full probation helps assure completion of probation.

If funding ends: Cases would be shifted to drug court, but not all counties have a drug court. ADP should propose legislation allowing counties to use monies for similarly-situated clients who do not technically meet Proposition 36 requirements. Some counties have Proposition 36 money that cannot be used.

Dual diagnosis clients: This remains a major treatment need in smaller counties, which have difficulty integrating substance abuse and mental health treatment. Some have assigned mental health workers to assist in screening and diagnosis, and some use a Registered Nurse to handle medication management. Experience has demonstrated the importance of doing cross-training for mental health and drug and alcohol counselors. The county may contract with board and care facilities for housing dual diagnosis clients. In some counties, a Licensed Clinician is part of the treatment team; but, some county mental health teams will not accept intoxicated clients, leading to the solution of using padded jail cells with an observer to assure that clients do not harm themselves.

Representatives of Butte, Colusa, El Dorado, Glenn, Lake, Mendocino, Napa, Nevada, Sutter, Yolo and Yuba

Modifications due to funding concerns: Representatives of five counties said they had made such modifications and one (Napa) said the county had not. Fund shortages have led to a loss of services available to clients in some cases.

If funding ends: Some counties had considered setting December 2005 as a cut-off date for accepting new Proposition 36 clients; however, this is considered inappropriate because of the way the law is worded. Clients might be transferred to the mental health department. Counties could shift directly to a drug court model, making certain that fees are collected from clients.

Dual diagnosis clients: Some counties provide treatment and case monitoring, but others report they have no services for dually diagnosed clients, who are sent directly to mental health. According to one participant, the financial reality is that some clients just do not receive the services they require.

Representatives of Del Norte, Humboldt, Imperial, Kings, Lassen, Madera, Merced, Shasta, Siskiyou and Tehama Counties

Modifications due to funding concerns: Many examples of program modifications were described, including:

- not filling a case-manager position or not providing case-management services at all;
- sending clients to outpatient treatment even when they have been assessed as needing residential treatment;
- creating waiting lists for residential treatment, and encouraging clients to go into treatment on their own to avoid being violated for dirty tests while waiting for a treatment slot to open;
- sending eligible clients to Native American health services;
- reducing numbers of probation officers and increasing caseloads for probation officers;
- increasing caseloads for drug and alcohol counselors; and,
- some needs for literacy training are going unfulfilled.

Some counties had planned to use LCSW's and other highly-credentialed staff to provide counseling services, but funding problems led to using alcohol and drug counselors instead.

If funding ends: Counties expressed concern about possibly losing their carry-over funds; they were counting on these to carry them through the transition. Counties want to get out the word on SACPA successes, but they need statewide data from ADP to help.

Dual diagnosis treatment: In some counties, assessments are made first in the treatment program, leading to referral of dual diagnosis clients to mental health. In other counties, dual diagnosis treatment is incorporated into alcohol and drug treatment. A need was expressed to provide for dual diagnosis certification, allowing mental health systems to provide alcohol and drug treatment along with mental health services.

Representatives of Kern, Monterey, Placer, San Luis Obispo, Santa Barbara, Tulare and Ventura Counties

Modifications due to funding concerns: Monterey County is requiring a special status evaluation and continuing authorization every 90 days. The county takes the frugal approach of saving early to ensure that available funds will stretch through the end of

the fiscal year. The county also uses specialty courts whenever possible. While the Kern County Probation Department would like to become involved in early intervention, available resources do not provide for this. The county receives about 100 hours a week of service by interns from CSU Bakersfield.

In San Luis Obispo County, budgetary restraints reduce the number or frequency of treatment review hearings, and fewer treatment slots will be available for non-entitled clients. Clients motivated to self-refer to treatment may be disappointed to find that they do not qualify for treatment without a specific entitlement. Tulare County has run its Proposition 36 program entirely within its budget and has not reduced other funding sources to subsidize Proposition 36 services--its entire level of treatment is structured to the allocation it receives. Ventura's assessment center is currently not fully staffed due to a county hiring freeze.

Client fees are charged in some counties, and help engage the client in his or her own treatment. Fees are around $50 a month, up to a high of $1,000 for a full 18 months of treatment and aftercare. Kern County performs random urine testing on a weekly basis and charges clients $13 a week for the testing. Thus, cost is not an issue for the county, and many probation officers feel that paying for the test helps a client feel responsible for his or her own treatment.

Dual diagnosis clients: Some counties feel the percentage of dual diagnosis cases among Proposition 36 clients is higher than what was indicated in presentations at the conference. Some drug treatment programs are reluctant to admit clients who require psychotropic medication for their mental health problems. Placer County takes pride in its "assessment machine" that uses both alcohol and drug and mental health practitioners for assessments. Placer also has a mental health court that receives the most disturbed dual diagnosis cases.

In Santa Barbara County, the mental health staff identifies any need for more extensive evaluation. Dual diagnosis services begin in the mental health setting, while clients with less severe disorders go through alcohol and drug treatment first. The Kern County representative noted that Kern has inadequate services for the "walking wounded" who have persistent but less severe problems. Monterey County employs a psychiatrist and an LCSW on its Proposition 36 assessment team to work with people of marginal eligibility who do not qualify for treatment within the county's mental health system. Santa Barbara County is trying to move people with co-occurring disorders into mental health group services. Kern County describes its services to the developmentally disabled as "habilitation" rather than "rehabilitation."

Innovative practices: Kern County uses a token reward system for clients. Showing up at least 10 times a month results in special privileges. Another county uses a "passport" system in which points earned for positive behaviors can be banked and traded for rewards. One county operates a special Saturday morning group for clients who are causing problems, separating them temporarily from their primary group and imposing the sanction of having to get up early on Saturdays to attend the special group

sessions. Santa Barbara County uses a protocol developed by CalWORKs to handle clients with learning disabilities that otherwise complicate treatment.

Representatives of Marin, San Joaquin, San Mateo, Santa Cruz, Solano, Sonoma and Stanislaus Counties

- *Modifications due to funding concerns:* (It was noted that, where people were being under-treated, they were still being held accountable.) Modifications cited include:

- reducing outpatient treatment to three months;
- allowing for an extension if requested and justified;
- changes in the drug-testing program;
- cutbacks on residential programs; and,
- shortening the residential stay from six months to two months.

If funding ends: The system will look different, because some services would be cut. There is a need to follow the letter of the law rather than the spirit of the law. There is a major question as to who would pay should treatment be considered a mandate under the law.

Dual diagnosis treatment: Some counties find it difficult to find services for the dually diagnosed who do not meet the criteria. Treatment providers have contracted with the county mental health program for services, but clients without Medi-Cal eligibility do not get the same treatment as those who are under Medi-Cal. Other solutions included providing an intensive outpatient program staffed with experienced clinicians, and hiring a private therapist with Proposition 36 funds to work with dual diagnosis clients.

Strategies to engage and retain clients: There were several strategies mentioned, including:

- Quick assessment and transportation to a treatment facility on the same day;
- Transportation from court to treatment within 72 hours, with extensive interaction with probation officer;
- Judge assigns client to get assessment by the following week and return to court with treatment outline; and,
- Judge gives the client the next assignment.
- Reducing the time between assessment and entry into treatment was cited by most as the key to client engagement.

Representatives of Alameda, Contra Costa, Sacramento, San Francisco, Santa Clara and San Mateo Counties

The county representatives agreed that the projections for the number of dual diagnosis clients to be expected in implementing Proposition 36 were low. Adjustments in budget distribution have been necessary to account for the unanticipated high numbers of

dually diagnosed clients. It was noted in the event Proposition 36 funding is not renewed, one enduring outcome is that all entities have learned the value of networking with a focus on system-to-system relationships as opposed to person-to-person relationships. Communication and collaboration are key elements in any successful program. Additional shared program successes include:

- Client treatment and case management are handled on a case-by-case basis especially with those who are dually diagnosed.
- Effective case management models show close working relationships between the mental health providers and probation officers.
- There needs to be aggressive outreach to clients in remote areas where transportation is limited. Working with public transportation can make passes available for use by clients participating in treatment.
- Creating special Proposition 36 group gatherings where participants can see a posting of their total clean and sober days and anticipated dates of program completion. In addition, weekly success stories are shared. Admittance to weekly group meetings are based on completed 12-step cards from the previous week's meetings. These meetings are not required but serve as a reward for those who are meeting their treatment plan requirements.
- Identifying residential drug treatment placements for clients prior to release from mental health.
- Clients generally do better in recovery when treatment time is extended as opposed to intense treatment over a shorter length of time.
- There is increased client success when a mental health provider works closely with the probation officer to develop a treatment plan. Mental health providers help probation officer understand the complexities of clients who are dually diagnosed, allowing clients to be treated more respectfully.
- In locations that have limited treatment opportunities for clients the treatment team may travel to the client as opposed to the client having to travel to the provider.
- Some counties have set up shuttles to accommodate travel issues of clients who have no access to public transportation.
- San Francisco County has found that results improve when the treatment time is less intensive and carried out over a longer period of time. In addition, transition homes are used as "safety nets" for those who have completed their initial treatment phase.

In the process of identifying positive aspects of county programs, the group identified these potential stumbling blocks that could impede the overall long-term success of Proposition 36 programs:

Law enforcement views Proposition 36 as a "revolving door." Officers may perceive that they make contact with an individual, take them in to custody, and then see the individual back out on the street immediately. It is believed that Law Enforcement at the field level does not fully understand how Proposition 36 actually works. It was suggested that field officers have access to the mechanics of Proposition 36.

• Treatment programs for dually diagnosed clients are very expensive.
• Funding for medication used to treat dually diagnosed clients runs short of necessary treatment time.
• Many dually diagnosed clients have additional health issues outside of mental illness and drug addictions with no available funding for necessary treatment.
• If Proposition 36 funding expires, treatment services will disappear for those currently participating. It is feared that many will be cutoff in the middle of their treatment.

Suggestions for overall improvement of implementation include:

• Training for law enforcement, including all levels from the street officer up the chain of command, from arrest to court and all contacts in between. There are instances where the arresting officer does not understand the role of the probation officer and vice versa.
• Conveying to law enforcement the importance of quick treatment for dually diagnosed clients.
• Better attendance by law enforcement at Technical Assistance conferences.
• Some probation officers have made themselves available for 24 hour phone contact. When clients finds themselves in trouble, they can call and get directions on where they can go to receive immediate help or benefit just from hearing a voice that supports them in their recovery.

The group strongly believes that if Proposition 36 funding is discontinued, the treatment and care currently received by eligible clients will cease to be available. That being said, there is strong support for all entities to actively promote the collaboration between stakeholders and the current administration.

Representatives of Fresno, Los Angeles, Orange, Riverside, San Bernardino and San Diego Counties

Modifications due to funding concerns: All five counties in the group reported they had made modifications to deal with funding problems.

If funding ends: San Bernardino County is hoping to convince the Board of Supervisors that continuing to fund Proposition 36 services is more cost-effective than going without the programs. There is a need to provide outcome data and other statistics to bolster this argument. Los Angeles County hopes to do the same, and points out it needs the buy-in of law enforcement to take its case to the Legislature. There are barriers that prevent employees from lobbying on the issue. Orange County is pulling together groups to make an appeal to the Legislature for continued funding. Riverside County is searching for ways to convince the decision-makers that Proposition 36 programs are an effective use of taxpayer dollars. In San Diego County, a policy group takes the position that the funding of the program is a state issue, not a local one, and is planning a campaign to convince the Legislature of this.

Dual diagnosis treatment: In San Diego County, there is a Psychiatrist on the Proposition 36 team, and a mental health screening may be requested during assessment. The county contracts with UCSD for psychiatric treatment of Proposition 36 clients. There are four outpatient programs for dual diagnosis clients in the county. In Riverside County, counselors in the courtroom make a decision on the need for dual diagnosis treatment. There are two contracted programs for treatment and four county-operated facilities where it can be provided. A START team provides a link between mental health and substance abuse treatment, and transportation can be provided for better management of a client's needs. A local judge has noted that while Proposition 36 was enacted to treat alcohol and drug addiction, it is actually treating mental health. Orange County reports that every client goes through a mental health screening in the course of a drug and alcohol assessment, and there are more than 30 contracted programs for treatment of dual diagnosis clients.

A special "dual diagnosis court" can handle up to 70 of the more severely afflicted clients. Dual diagnosis treatment is considered very expensive, and clients often need more than the 12 months covered by Proposition 36. In Los Angeles County, clients move directly from the assessment center to an appropriate treatment facility. If immediate release into the community is considered dangerous, some clients can be placed in a county jail facility. Between 20 to 22 courts are handling Proposition 36 cases in Orange County, and there are not enough facilities to handle the load of up to 10,000 Proposition 36 cases. San Bernardino County refers its dual diagnosis clients to one of five county-operated clinics. Teleconferencing is used for communication with clinics in outlying areas. The county is contracting for additional dual diagnosis residential beds.

Strategies to engage and retain clients: In San Diego County, regular meetings between providers and parole provide an opportunity for dialogue about the treatment process and any need for changes and reorientation. Hearings are scheduled at 30 day intervals for review of cases. Riverside County reports there is considerable dialogue between treatment providers and the supervising agency regarding measures to keep clients engaged. Orange County provides walk-in assessments for immediate placement, and courts receive continuous feedback through monitoring five days a week. Probation, health care and treatment providers do case reviews and can reduce expenditures by identifying clients who are not interested in treatment or not benefiting from it. Los Angeles County also tries to avoid delays in getting clients into treatment. The courts can re-assess clients for placement in a higher level of care, but there is insufficient time for the kind of motivational interviewing that might make treatment more effective. San Bernardino County has learned that it will lose clients if assessment and probation facilities are not located in the same building. Maintaining a culture of "best practices" is difficult because of the size of the county.

Innovative practices: Los Angeles schedules meetings four times a year of public defenders, treatment providers, probation, bench officers and parole officers for a roundtable discussion of problems and progress. An attitude of "call me" is encouraged

for those having a problem with a client. One judge has providers bring all of their clients to the court at the same time—a measure that has resulted in a decrease in failure-to-appear rates. Orange County distributes cases so there is one officer assigned to dual diagnosis cases. Ten officers supervise clients with the highest risk for re-offense and have a reduced caseload of 90 (ordinarily the 18 officers in the county have an average caseload of 200). The team is asking the court to allow a more limited monitoring of aftercare so funds can be moved to new cases. In San Diego County, the parole department has assigned two officers who are responsible only for Proposition 36 clients. A “parolee accountability review” is enjoying success in delivering sanctions and rewards. A critical incident review board including probation, treatment providers, mental health and the courts debrief an incident to see if or how it could have been avoided. San Bernardino County reports a benefit from collaboration and communication between counties, with clients being held accountable regardless of their location.